

(Assigned by Privacy Official)

# HIPAA PRIVACY COMPLAINT FORM

This form must be used to file a Health Insurance Portability and Accountability Act (HIPAA) privacy complaint with the Privacy Official for the state health plans administered by the Employee Benefits Division. Before completing and filing this form, see Michigan Department of Civil Service Regulation 5.18, *Group Insurance Plan Complaints*, and Regulation 8.06, *Computing Time and Filing Documents*, available on the web at [www.michigan.gov/mdcs/0,1607,7-147-6877---,00.html](http://www.michigan.gov/mdcs/0,1607,7-147-6877---,00.html) or at your personnel office. The Privacy Official will review the complaint and provide a written response to all interested parties.

**NOTE:** To file a privacy complaint with the Privacy Official, you must mail it to the address above, fax it to (517) 373-3174, or e-mail it to [MDCS-HIPAA@michigan.gov](mailto:MDCS-HIPAA@michigan.gov). You must include in this filing all underlying and relevant documents. The Privacy Official may also be contacted by telephone at (517) 373-7977 or (800) 505-5011.

COMPLAINANT'S NAME (Please print)		EMPLOYEE ID NO.		WORK PHONE NO. (and EXT.)	
COMPLAINANT'S HOME MAILING ADDRESS		CITY		STATE	ZIP CODE
HOME PHONE NO.		FAX NUMBER		E-MAIL ADDRESS	
INFORMATION ABOUT YOUR COMPLAINT REGARDING YOUR PERSONAL HEALTH INFORMATION (PHI)					
PERSON OR ORGANIZATION COMPLAINT IS AGAINST:		DATE YOU FIRST NOTICED ACTION:		DATES ACTIONS OCCURRED:	
Please check the appropriate reason for your complaint and provide your statement below.					
<input type="checkbox"/> My protected health information (PHI) was inappropriately used.			<input type="checkbox"/> I was inappropriately denied access to my PHI.		
<input type="checkbox"/> My PHI was inappropriately disclosed.			<input type="checkbox"/> I was inappropriately denied amendments to my PHI.		
<input type="checkbox"/> My PHI was inappropriately disposed.			<input type="checkbox"/> Privacy policies violate HIPAA requirements.		
STATEMENT: Specifically describe what happened and the effect on your PHI or privacy. (Attach and label additional sheets, if needed.)					
WITNESSES: If you have witnesses, please provide names and contact information. (Attach and label additional sheets, if needed.)					
WITNESS NAME:		ADDRESS:		TELEPHONE NUMBER:	
RELIEF SOUGHT: Please describe how your privacy complaint could be resolved.					
SIGNATURE				DATE	

**KEEP A COPY FOR YOUR RECORDS**